REMARKS OF

THE HONORABLE

HENRY A. WAXMAN,

CHAIRMAN,

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

BEFORE

THE COMMITTEE OF NATIONAL HEALTH INSURANCE

810305

REMARKS OF THE HONORABLE HENRY A. WAXMAN

CHAIRMAN, SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

BEFORE

THE COMMITTEE FOR NATIONAL HEALTH INSURANCE

MARCH 5, 1981

I'D LIKE TO SPEAK TO YOU TODAY ABOUT THE ADMINISTRATION'S PROPOSED CUTS IN HEALTH CARE SPENDING, THE IMPLICATIONS OF THOSE CUTS FOR YOU, AND YOUR CONSTITUENTS, AND THE PROSPECTS FOR ADOPTION OF THOSE PROPOSALS IN THE HOUSE.

LET ME SAY AT THE OUTSET THAT THE UPCOMING DEBATE HAS ENORMOUS IMPLICATIONS, ~~NOT ONLY FOR THE PROGRAMS DIRECTLY AFFECTED, BUT MORE FUNDAMENTALLY FOR THE MOVEMENT FOR A COMPREHENSIVE, UNIVERSAL NATIONAL HEALTH PLAN.~~ IF THE ADMINISTRATION IS ALLOWED TO HAVE ITS WAY, THE NEXT FEW YEARS WILL SEE A MASSIVE RETREAT BY THE FEDERAL GOVERNMENT.

-- A RETREAT FROM ITS RESPONSIBILITY TO ASSURE THAT THE POOR, THE DISABLED, AND THE ELDERLY HAVE ACCESS TO NEEDED CARE:

-- A RETREAT FROM ITS RESPONSIBILITY TO MODERATE THE UNREASONABLE RATE OF INFLATION IN HEALTH CARE COSTS:

-- A RETREAT FROM ITS RESPONSIBILITY TO FOSTER IMPROVEMENTS IN THE HEALTH CARE DELIVERY SYSTEM.

IN SHORT, THE FUNDAMENTAL PRINCIPLES TO WHICH YOUR ORGANIZATION IS COMMITTED WOULD BE THOROUGHLY REPUDIATED WERE THE ADMINISTRATION'S RECOMMENDATIONS ADOPTED.

ON FEBRUARY 18, THE PRESIDENT ANNOUNCED A SWEEPING SERIES OF PROPOSALS TO:

-- PLACE A CEILING ON FEDERAL MATCHING PAYMENTS TO STATES TO ASSIST THEM IN MEETING THE COSTS OF THEIR MEDICAID PROGRAMS:

-- LUMP MOST OF THE FEDERAL CATEGORICAL GRANT PROGRAMS INTO ONE LARGE HEALTH AND SOCIAL SERVICES PROGRAM "CONSOLIDATION," CUT THE TOTAL FUNDING LEVEL BY 25% FROM FY 1981 LEVELS, AND TURN THE ENTIRE "BLOCK" OVER TO THE STATES TO MAKE THE SPECIFIC CUTS.

-- TERMINATE THE NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM, LEAVING ABOUT 2/3 OF THE 12 MILLION PEOPLE NOW LIVING IN URBAN AND RURAL HEALTH MANPOWER SHORTAGE AREAS WITHOUT ACCESS TO PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

-- PHASE OUT THE HEALTH PLANNING AND PSRO PROGRAMS AT A TIME WHEN HOSPITAL EXPENSES, WHICH THESE PROGRAMS ARE INTENDED TO MODERATE, ARE RISING AT MORE THAN A 17% CLIP.

-- PHASE OUT THE FEDERAL GRANT AND LOAN PROGRAM FOR HEALTH MAINTENANCE ORGANIZATIONS (HMOs), LEAVING POTENTIAL NEW ENTRANTS INTO THE HMO BUSINESS TO FIND PRIVATE CAPITAL.

-- ELIMINATE THE PUBLIC HEALTH SERVICE HOSPITAL AND CLINIC SYSTEM, LEAVING THE STATUTORY BENEFICIARIES AND THE COMMUNITIES NOW DEPENDENT UPON MANY OF THOSE FACILITIES TO SEARCH FOR ALTERNATIVE SOURCES OF CARE.

OSTENSIBLY, THESE PROPOSALS ARE "BUDGET CUTS," DESIGNED TO REDUCE THE RATE OF INCREASE IN FEDERAL HEALTH OUTLAYS, REDUCE THE BUDGET DEFICIT, AND THROUGH SOME MAGICAL PROCESS LEAD TO NATIONAL ECONOMIC RECOVERY. HOWEVER, IF WE LOOK CAREFULLY, IT BECOMES CLEAR THAT MUCH MORE IS GOING ON HERE THAN MERE BUDGET CUTTING. THE ADMINISTRATION IS TRYING TO MOVE A MUCH BROADER IDEOLOGICAL AGENDA.

IT IS SEEKING TO END THE FEDERAL HEALTH CARE ENTITLEMENT PROGRAMS AS WE KNOW THEM. IT WANTS TO ELIMINATE THE FEDERAL CATEGORICAL GRANT PROGRAMS. IT HOPES TO DISMANTLE AT LEAST ONE OF THE FEDERAL DELIVERY SYSTEMS. AND IT INTENDS TO PHASE OUT THE FEDERAL PROGRAMS DESIGNED TO RESTRAIN UNNECESSARY CAPITAL EXPENDITURES AND REDUCE UNNECESSARY HOSPITAL UTILIZATION.

WHO WILL BE RESPONSIBLE FOR MEETING THE NEEDS THAT THESE PROGRAMS NOW SERVE ONCE THE FEDERAL GOVERNMENT HAS WITHDRAWN? IN SOME CASES, THE STATES AND LOCALITIES ARE APPARENTLY EXPECTED TO PICK UP THE BALL; IN OTHERS, THE CONVENIENTLY NONSPECIFIC "PRIVATE SECTOR." AT SOME UNIDENTIFIED POINT DOWN THE ROAD, THE ADMINISTRATION PROMISES "COMPREHENSIVE LEGISLATION TO REMEDY MARKET DISTORTIONS IN THE HEALTH CARE SYSTEM." WHAT HAPPENS IN THE INTERIM? NO ONE SEEMS TO KNOW.

PRESIDENT REAGAN'S SPEECHWRITERS CALL THIS AMERICA'S "NEW BEGINNING." TO ME, IT LOOKS LIKE THE BEGINNING OF THE END. IF ENACTED, THESE PROPOSALS WILL SET BACK THE MOVEMENT FOR ~~A COMPREHENSIVE, UNIVERSAL NATIONAL HEALTH PLAN~~ adequate health care for all Americans FOR MANY YEARS BEYOND MR. REAGAN'S TERM IN OFFICE.

LET'S LOOK AT THE MEDICAID CAP AND BLOCK GRANT PROPOSALS IN A LITTLE MORE DETAIL. I THINK YOU'LL SEE THAT, PRESIDENT REAGAN'S RHETORIC NOTWITHSTANDING, THE ADMINISTRATION BUDGET WILL RIP HUGE HOLES IN AN ALREADY TATTERED "SAFETY NET" AND MAY WELL AGGRAVATE THE ALREADY EXCESSIVE INFLATION IN HEALTH CARE PRICES.

MEDICAID "CAP"

FROM THE STANDPOINT OF THE NUMBER OF PEOPLE AND THE AMOUNT OF MONEY INVOLVED, THE LARGEST CUTS HAVE BEEN TARGETED AT THE PROGRAM FOR THE POOR AND DISABLED -- MEDICAID. THE ADMINISTRATION PROPOSES TO END THE "ENTITLEMENT" NATURE OF THIS CRITICAL HEALTH CARE FINANCING PROGRAM, SETTING A CEILING ON FEDERAL OUTLAYS IN FY 1981 AT $100 MILLION BELOW ESTIMATED LEVELS, AND ALLOWING FEDERAL OUTLAYS IN FY 1982 TO RISE ONLY 5% FROM THAT REDUCED 1981 BASE. THE FEDERAL "SAVINGS" IN FY 1982 ARE ESTIMATED AT $1.013 BILLION; BY FY 1986, THIS "SAVINGS" WILL BALLOON TO AN ESTIMATED $5.021 BILLION. COUPLED WITH THIS REDUCTION IN FEDERAL CONTRIBUTIONS, THE ADMINISTRATION WOULD GIVE THE STATES MORE "FLEXIBILITY" TO QUICKLY ALTER THEIR ELIGIBILITY, BENEFITS, AND REIMBURSEMENT POLICIES IN UNSPECIFIED WAYS.

THIS PROPOSAL MAKES A NUMBER OF DUBIOUS ASSUMPTIONS, NOT THE LEAST OF WHICH IS THAT THERE IS ALL SORTS OF FAT IN THE MEDICAID PROGRAM. THOSE OF YOU FAMILIAR WITH THE REAL WORLD WILL RECOGNIZE THAT IN MANY STATES, THE AVAILABLE TAX IS SIMPLY NOT EXPANDING AT THE SAME RATE THAT PRICES IN THE MEDICAL CARE SECTOR, WHERE MEDICAID PURCHASES SERVICES, ARE INCREASING. THE RESULT IS, INEVITABLY, A SHORTFALL. IN A RECENT SURVEY CONDUCTED BY THE INTERGOVERNMENTAL HEALTH POLICY PROJECT AT G.W. UNIVERSITY, MORE THAN HALF OF THE STATES IDENTIFIED MODERATE TO SERIOUS FUNDING PROBLEMS WITH THEIR MEDICAID BUDGETS THIS FISCAL YEAR. SOME HAVE ALREADY INITIATED CUTBACKS IN ELIGIBILITY OR BENEFITS.

THE ADMINISTRATION'S PROPOSAL WILL ONLY MAKE MATTERS WORSE. AT A TIME WHEN MANY STATES COULD USE EVEN MORE FEDERAL FUNDS JUST TO FULFILL THEIR CURRENT COMMITMENTS, EVEN LESS FEDERAL FUNDS WILL BE MADE AVAILABLE. STATES WILL HAVE LITTLE CHOICE IN SUCH CIRCUMSTANCES: CUT ELIGIBILITY, CUT BENEFITS, OR CUT REIMBURSEMENT RATES. AND THE ADMINISTRATION PROPOSES TO GIVE THEM THE FLEXIBILITY TO DO SO QUICKLY.

OBVIOUSLY, THE ADMINISTRATION DOES NOT PROPOSE TO CONTAIN MEDICAID COSTS, BUT TO SHIFT THEM. TO SHIFT THEM ONTO THE STATES. TO SHIFT THEM ONTO THE COMMUNITIES AND CITIES, WHICH IN MANY AREAS BEAR THE FINAL STATUTORY RESPONSIBILITY TO PROVIDE HEALTH CARE TO THE POOR. TO SHIFT THEM TO THE BENEFICIARIES, WHO WILL HAVE TO FEND TOR THEMSELVES ONCE THEIR MEDICAID CARD IS TERMINATED AND THE LOCAL PUBLIC HOSPITAL DOOR IS CLOSED.

BLOCK GRANT

THE PRESIDENT ALSO PROPOSED ON FEBRUARY 18 TO "CONSOLIDATE" ABOUT 40 DIFFERENT HEALTH AND SOCIAL SERVICES PROGRAMS INTO ONE "BLOCK GRANT" TO THE STATES, CUTTING THE FUNDING LEVEL TO 75% OF THE CURRENT 1981 BASE. THE STATES, HAVING RECEIVED THE OPPORTUNITY TO "MANAGE" THESE PROGRAMS, WOULD GET TO CHOOSE BETWEEN MAKING UP THE FEDERAL FUNDING SHORTFALL OUT OF THEIR OWN POCKETS OR TERMINATING SOME OR ALL OF THE SERVICES.

NOW IF THE ADMINISTRATION WERE TRYING ONLY TO REDUCE FEDERAL OUTLAYS FOR THESE PROGRAMS, IT COULD SIMPLY ASK FOR REDUCED APPROPRIATIONS LEVELS. UNFORTUNATELY, IN MANY OF THESE CATEGORICAL PROGRAMS, REDUCTIONS HAVE ALREADY OCCURRED AS MORE AND MORE FEDERAL DOLLARS HAVE BEEN DIVERTED TO FINANCE THE INFLATION IN ENTITLEMENT PROGRAMS. BUT THE ADMINISTRATION WANTS TO DO MORE THAN FURTHER CUT FEDERAL OUTLAYS. IT WANTS TO END THE FEDERAL RESPONSIBILITY FOR THESE PROGRAMS AND THE PEOPLE THEY SERVE. AND AGAIN, WHAT MORE CONVENIENT WAY IS THERE TO ACCOMPLISH THIS THAN DUMPING THE PROGRAMS -- WITH SUBSTANTIALLY LESS FUNDING -- ONTO THE STATES?

THE PROGRAMS PROPOSED FOR THIS CONSOLIDATION ARE UNBELIEVABLY DIVERSE. GRANTS TO STATES FOR TRADITIONAL PUBLIC HEALTH FUNCTIONS, SUCH AS V.D. TREATMENT, FLUORIDATION, AND IMMUNIZATIONS. GRANTS TO PRIVATE NONPROFIT ORGANIZATIONS FOR PRIMARY CARE DELIVERY IN MEDICALLY UNDERSERVED AREAS, GRANTS

TO STATES FOR CRIPPLED CHILDREN'S SERVICES. THE LIST GOES ON AND ON, BUT THE POINT IS CLEAR: THESE PROGRAMS BEAR NO RATIONAL ADMINISTRATIVE, PROGRAMMATIC, OR FINANCIAL RELATIONSHIP TO ONE ANOTHER. INDEED, MANY ARE ALREADY ADMINISTERED BY THE STATES WITHIN A FRAMEWORK THAT REFLECTS A CAREFUL ACCOMMODATION OF FEDERAL AND STATE INTERESTS; THE MOST RECENT EXAMPLE HERE IS THE MENTAL HEALTH SYSTEMS ACT.

IN THE CASE OF THE HEALTH-RELATED CATEGORICAL PROGRAMS THAT THE ADMINISTRATION WOULD LIKE TO CUT AND BLOCK, THERE IS GENERALLY A SOUND POLICY REASON WHY THE FEDERAL GOVERNMENT IS INVOLVED. USUALLY, IT IS BECAUSE THE STATES DO NOT HAVE THE FINANCIAL RESOURCES TO ADDRESS THE NEEDS OF THE POPULATION INVOLVED, OR BECAUSE THE STATES ARE RELUCTANT TO COMMIT RESOURCES WHEN THEY CANNOT COMPLETELY CAPTURE THE BENEFITS OF THEIR "INVESTMENT."

A CASE IN POINT IS THE MIGRANT HEALTH CENTER PROGRAM, WHICH PROVIDES FUNDS TO PUBLIC AND PRIVATE NONPROFIT ENTITIES TO DELIVER PRIMARY HEALTH SERVICES TO MIGRANT AND SEASONAL AGRICULTURAL WORKERS. THIS IS A POPULATION THAT HAS A HEALTH STATUS DEMONSTRABLY LOWER THAN THAT OF THE GENERAL POPULATION, BUT THAT CANNOT OBTAIN NEEDED HEALTH SERVICES FROM THE PRIVATE SECTOR DUE TO FINANCIAL OR GEOGRAPHICAL BARRIERS. THE STATES IN THE "MIGRANT STREAMS" CANNOT REASONABLY BE EXPECTED TO BEAR THE FULL FINANCIAL COSTS ASSOCIATED WITH THE CARE OF THESE INDIVIDUALS, PARTICULARLY WHEN MANY ARE RESIDENTS FOR ONLY A FEW WEEKS OR MONTHS PER YEAR. THUS THE FEDERAL INVOLVEMENT.

TO CONSOLIDATE MIGRANT HEALTH FUNDS INTO A REDUCED BLOCK GRANT IS SIMPLY TO RETURN TO THE CIRCUMSTANCES THAT CREATED THE NEED FOR THE PROGRAM -- LACK OF STATE FINANCIAL ABILITY OR WILLINGNESS TO PROVIDE PRIMARY CARE TO THIS UNDERSERVED POPULATION.

IT SHOULD BE OBVIOUS BY THIS POINT, IF THE ADMINISTRATION'S PROPOSALS ARE ADOPTED, THAT STATES AND LOCALITIES WILL SUDDENLY FIND THRUST UPON THEM THE RESPONSIBILITY FOR FINANCING MORE AND MORE OF THE COSTS OF A BROAD RANGE OF MEDICAL AND MENTAL HEALTH CARE SERVICES TO PEOPLE WHO ARE UNABLE TO OBTAIN PRIVATE INSURANCE COVERAGE. THESE INCLUDE LOW-INCOME CHILDREN, LOW-INCOME PREGNANT WOMEN, DISABLED AND CHRONICALLY ILL ADULTS, AND THE ELDERLY -- THE MOST VULNERABLE SEGMENTS OF OUR POPULATION. THE ADMINISTRATION HAS NOT TO MY KNOWLEDGE COME FORWARD WITH ANY EVIDENCE TO SUGGEST THAT THE STATES ARE IN A STRONGER FISCAL POSITION THAT THE FEDERAL GOVERNMENT TO RESPOND TO THE UNMET HEALTH NEEDS OF THIS POPULATION. IN FACT, IF ALL OF THE ADMINISTRATION'S PROPOSALS ARE ADOPTED, THE STATES WILL BE EVEN LESS CAPABLE OF FINANCING THESE HEALTH CARE PROGRAMS THAN THEY NOW ARE, SINCE THEY WILL ALSO BE FACING CUTS IN FEDERAL SUPPORT FOR MEDICAID AND A RANGE OF RELATED SOCIAL SERVICES PROGRAMS AS WELL.

I HOPE I'VE MADE THE CASE THAT THE ADMINISTRATION'S "BLOCK GRANT" AND "MEDICAID CAP" PROPOSALS WILL BE HARMFUL IN THE SHORT RUN. BUT THE LONG-RUN IMPLICATIONS OF THESE BLATANT COST-SHIFTING POLICIES IS EVEN MORE SOBERING.

CONSIDER TREASURY SECRETARY REGAN'S CONCESSION LAST WEEK THAT, IF THE ADMINISTRATION IS TO ACHIEVE THE BALANCED BUDGET THAT IT HAS PROMISED BY 1984, IT WILL NEED TO MAKE ADDITIONAL CUTS -- ABOVE AND BEYOND THOSE ALREADY PROPOSED -- OF ABOUT $31 BILLION FOR EACH OF THE NEXT THREE YEARS. WHERE WILL THESE CUTS BE FOUND? I WOULD SUGGEST TO YOU THAT ONCE THE TRANSFER OF RESPONSIBILITY FOR MEDICAID AND THE CATEGORICAL PROGRAMS TO THE STATES HAS BEEN ACCOMPLISHED, THE ADMINISTRATION WILL PROPOSE EVEN FURTHER REDUCTIONS IN THE FEDERAL FINANCIAL COMMITMENT TO THESE PROGRAMS.

NOR CAN WE TAKE MUCH COMFORT IN THE FACT THAT THE MEDICARE PROGRAM IS EXCLUDED FROM THIS FIRST ROUND OF CUTBACKS. ONCE THE ADMINISTRATION HAS STRIPPED THE LOW-INCOME ELDERLY AND DISABLED OF THEIR MEDICAID ENTITLEMENT, IT IS THEN LIKELY TO TURN ITS ATTENTION TO THE MEDICARE ENTITLEMENT, WHICH REPRESENTS AN EVEN LARGER AND MORE RAPIDLY EXPANDING COMMITMENT OF FEDERAL RESOURCES. WHETHER THE ATTACK TAKES THE FORM OF PROPOSALS FOR BENEFITS REDUCTIONS OR MORE COST-SHARING OR INTRODUCTION OF A MEANS TEST IS DIFFICULT TO PREDICT. BUT SO LONG AS HOSPITAL COSTS CONTINUE TO RISE AT CURRENT RATES, SUCH AN ATTACK IS INEVITABLE.

LET'S ASSUME THAT WE CHOOSE NOT TO RESIST, AND THAT MUCH OF THIS GRIM SCENARIO COMES TO PASS. WHAT MIGHT THE HEALTH CARE WORLD LOOK LIKE? -- THE NUMBER OF PEOPLE WITH NO PUBLIC OR PRIVATE INSURANCE COVERAGE WHATSOEVER -- ALREADY

MORE THAN 26 MILLION -- WILL GROW.

-- THE RESIDUAL STATE MEDICAID PROGRAMS WILL PURCHASE CARE FOR THEIR REMAINING ELIGIBLES AT REDUCED RATES FROM CERTAIN POOR PEOPLE'S HOSPITALS AND NURSING HOMES.

-- MANY MEDICARE BENEFICIARIES WILL FIND THAT THEY MUST PAY EVEN MORE OUT OF POCKET FOR NEEDED HEALTH CARE THAN THEY NOW DO, AND THAT MANY HOSPITALS WILL NO LONGER ACCEPT THEIR MEDICARE CARDS UNLESS THEY AGREE TO PAY A SURCHARGE TO COMPENSATE THE FACILITY FOR THE "LOSS" IT IS TAKING ON THE OFFICIAL MEDICARE REIMBURSEMENT RATE.

-- THOSE EMPLOYEES WITH ADEQUATE PRIVATE HEALTH INSURANCE COVERAGE WILL CONTINUE TO ENJOY "MAINSTREAM" CARE.

IN SHORT, WE WILL HAVE A HEALTH CARE SYSTEM IN WHICH "TWO CLASS" CARE IS EVEN MORE PRONOUNCED THAN NOW. THE POOR, THE DISABLED, THE ELDERLY, AND THE UNEMPLOYED WILL FIND THAT, IN THE ADMINISTRATION'S "MARKET SOLUTION," THEIR NEED FOR HEALTH SERVICES MAKES THEM TARGETS OF DISCRIMINATION RATHER THAN BENEFICIARIES OF AN ENTITLEMENT.

I HOPE THAT THIS WILL NOT COME TO PASS. AND I AM CONFIDENT THAT IF EACH OF THE ORGANIZATIONS IN THIS ROOM RECOGNIZES WHAT IS AT STAKE IN THESE BUDGET CUTS AND COMMUNICATES THAT CONCERN TO EACH AND EVERY MEMBER OF THE HOUSE AND SENATE, IT WILL NOT COME TO PASS.